SHARE
Finance Workgroup

APRIL 19, 2010

ARKANSAS CENTER FOR HEALTH IMPROVEMENT

MAIN CONFERENCE ROOM

2:30 PM TO 4:30 PM

Welcome & Introductions

Announcements & Updates

Use Cases

Arkansas Health Information Exchange (HIE)

MEDICAID HIE USE/BUSINESS CASES

Request Patient Records

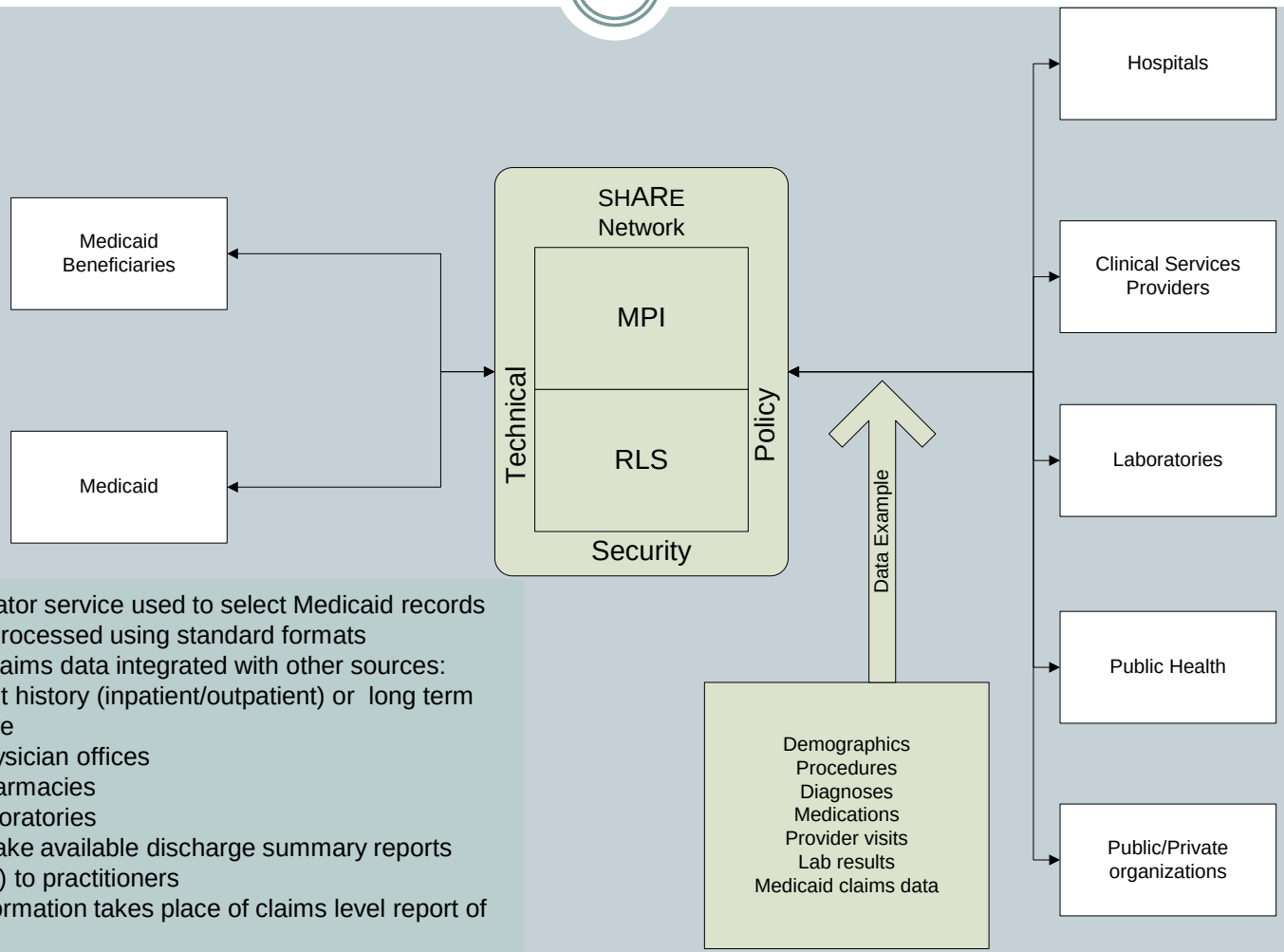
Patient clinical data is used to determine the health status and plan of treatment for patients

- **Benefits to Medicaid**
  - Actively assist in the management of care for high cost individuals
  - Monitor/manage episodes of care
  - Monitor/manage the coordination of services
  - Detect potential fraud and abuse
  - Develop/implement outcomes based payment methodology
- **Implementation Pathway:**
  - Medicaid claims data as a Record of Service
  - Medicaid Access to Provider EHR

MMIS HIE Capabilities:

- Record of Services
  - Medication History
  - Inpatient
  - Ambulatory Visit
- Disease/case management for chronic care coordination
- Prior authorization
- MMIS review/use clinical information

Request Patient Records



- Record locator service used to select Medicaid records
- Requests processed using standard formats
- Medicaid claims data integrated with other sources:
  - visit history (inpatient/outpatient) or long term care
  - physician offices
  - pharmacies
  - laboratories
- Hospital make available discharge summary reports (CCD/CCR) to practitioners
- Clinical information takes place of claims level report of services

Medication Prescribing / History

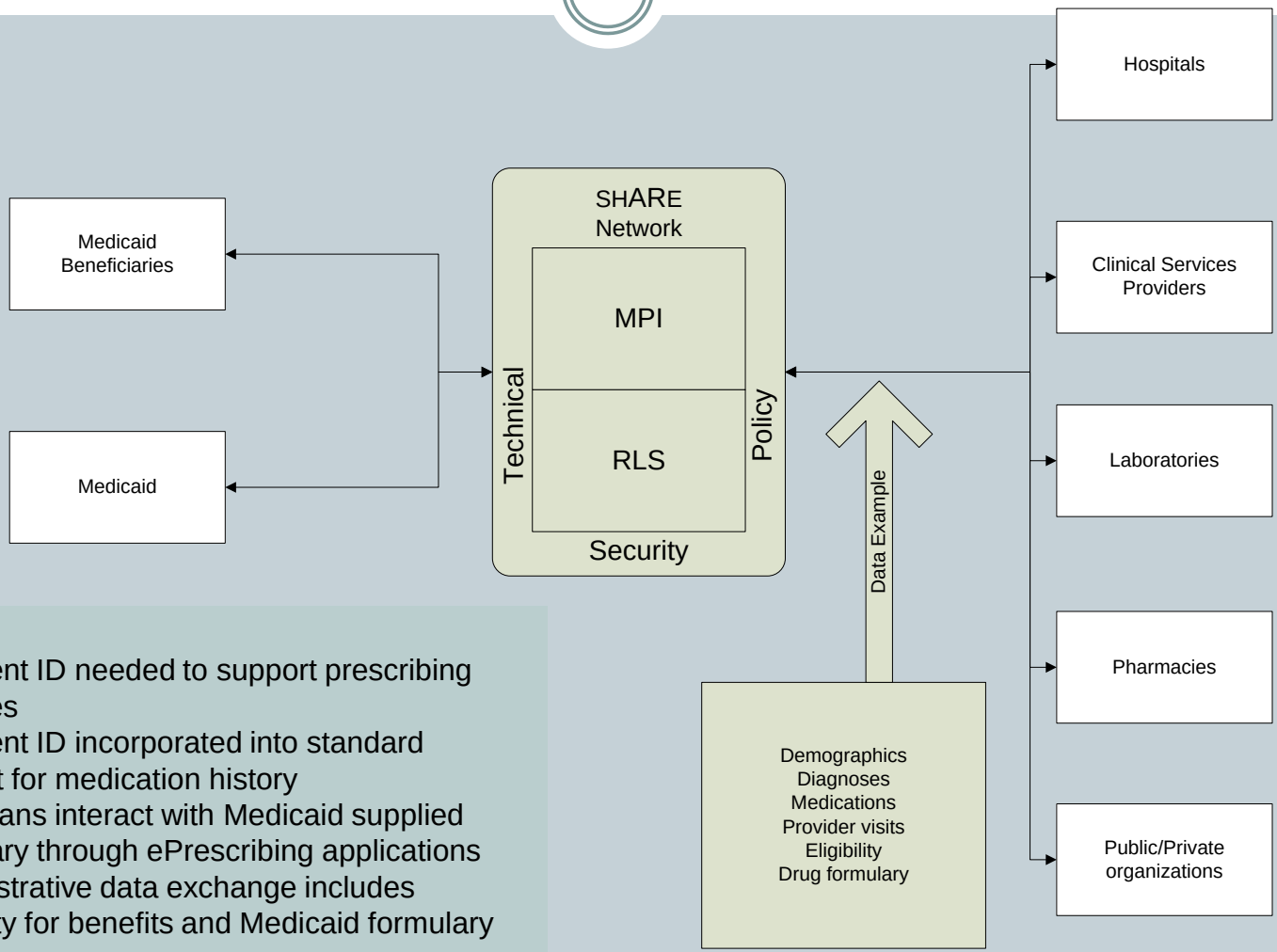
The reconciliation of prescribed medication with physician orders at point of treatment, with or without the generation of an electronic prescription

- **Benefits to Medicaid**
  - Reduce prescribing errors
  - Reduce poly pharmacy and fraud and abuse
  - Improve patient compliance
- **Implementation Pathway**
  - HIE access to Medicaid claims history as record of service
  - ePrescribing in stand alone system
  - ePrescribing in provider EHR

MMIS HIE Capabilities:

- Record of medication history
- Electronic eligibility verification
- Electronic claims transactions
- Other (Third Party Insurance ID) Prior Authorization
- MMIS Review
  - Use Clinical Information

Medication Prescribing/History



- Recipient ID needed to support prescribing activities
- Recipient ID incorporated into standard request for medication history
- Physicians interact with Medicaid supplied formulary through ePrescribing applications
- Administrative data exchange includes eligibility for benefits and Medicaid formulary

Exchange Clinical Data Between Providers

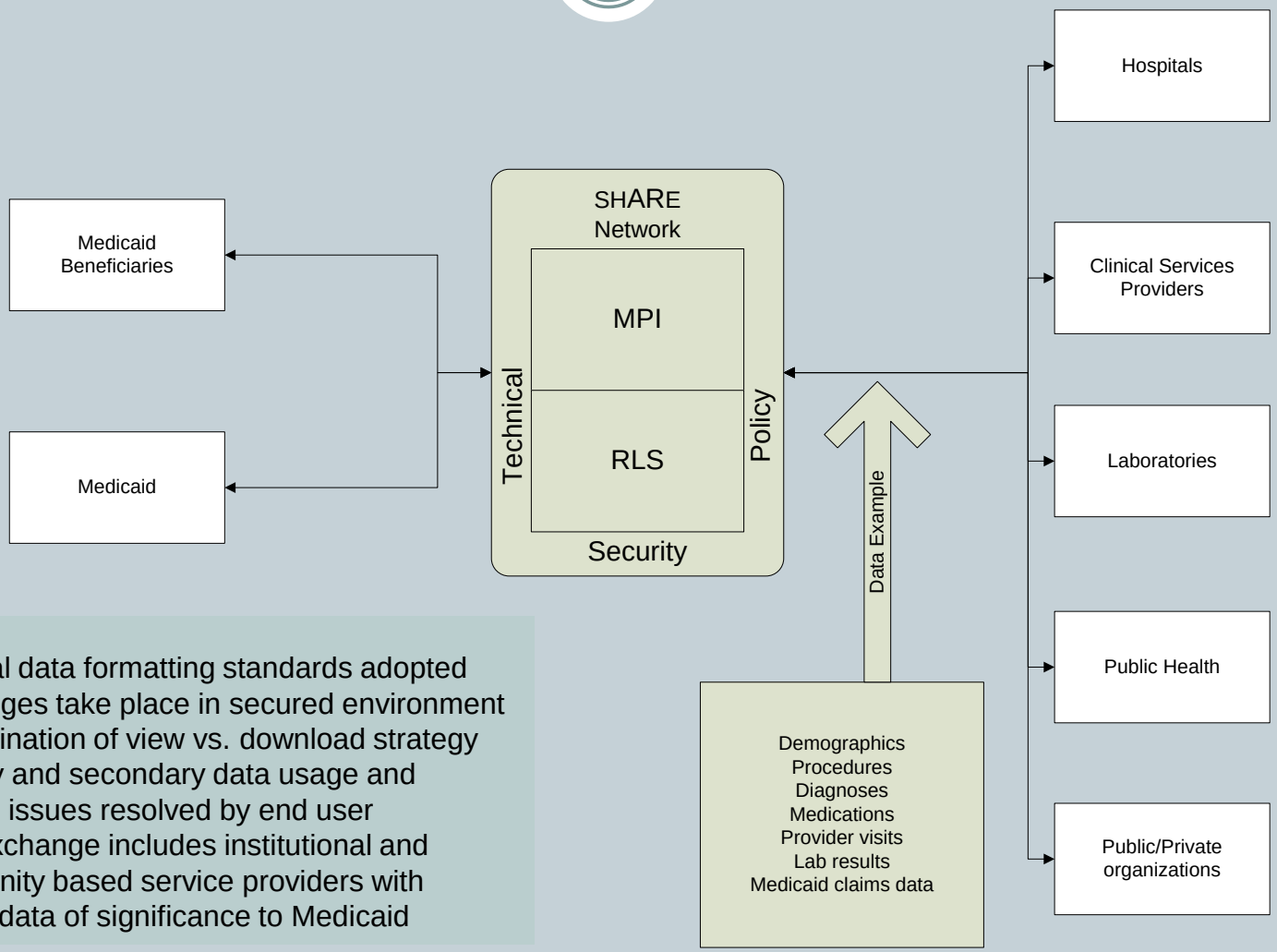
Clinical data exchange is the foundation of an HIE, providing timely access to relevant information to providers at the point of treatment.

- **Benefits to Medicaid**
  - Reduce the over utilization of lab tests
  - Reduce over utilization of radiological diagnostic procedures.
  - Improve treatment
    - Patient reported information
    - Problem lists,
    - Prior treatment records
  - More accurate demographic information
- **Implementation Pathway**
  - Provider access to Medicaid record of service
  - Web based EHR light
  - Provider EHR

MMIS HIE Capabilities:

- Lab results
- Reporting disease
- Case management for chronic care coordination
- Care Coordination
  - Other Treating Providers/Link
- Audit verification of meaningful use
- Patient monitoring

Exchange of Clinical Data Between Practitioners



- National data formatting standards adopted
- Exchanges take place in secured environment
- Determination of view vs. download strategy
- Primary and secondary data usage and storage issues resolved by end user
- Data exchange includes institutional and community based service providers with clinical data of significance to Medicaid

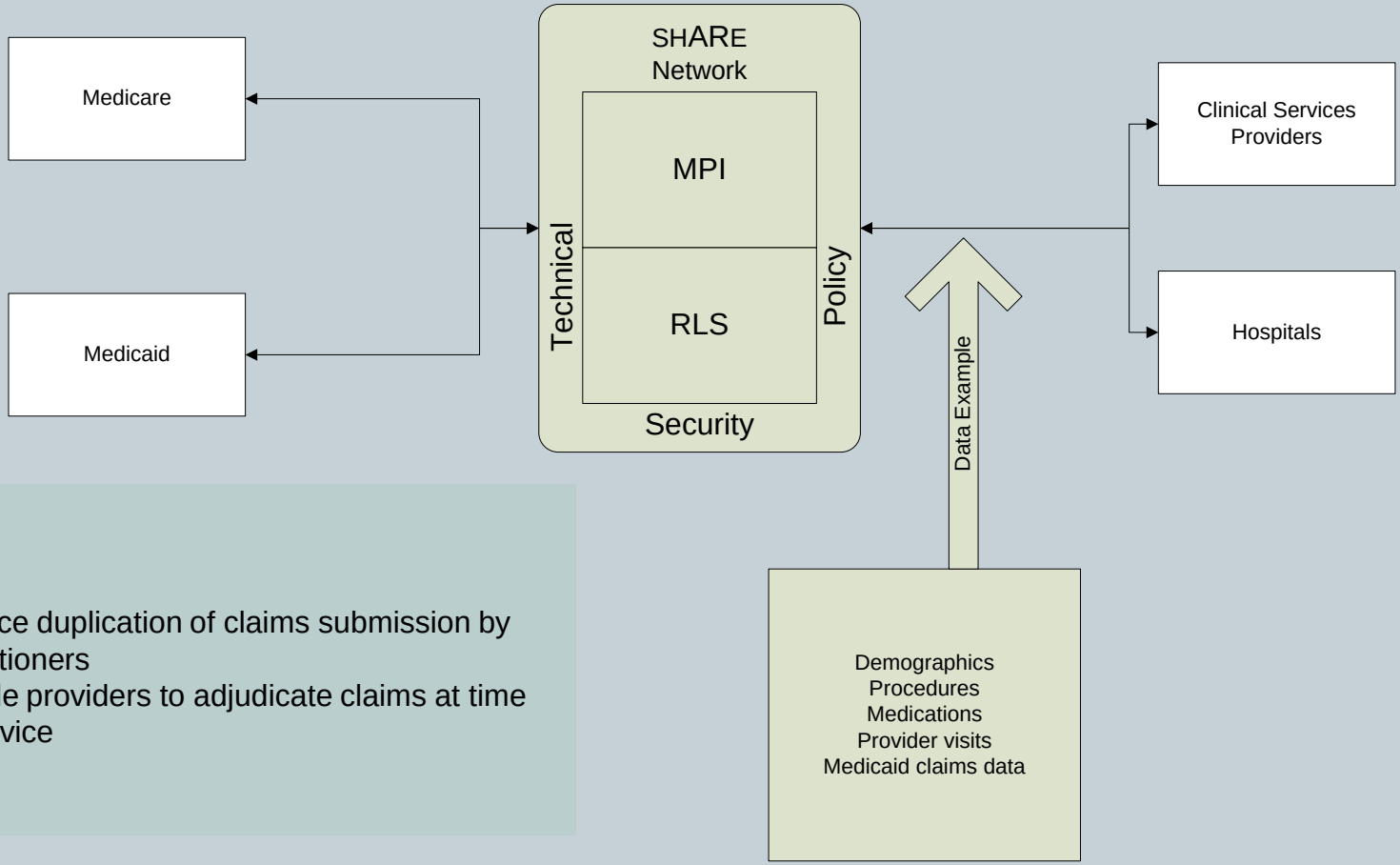
Claims Processing

- Medicaid has current capabilities for electronic claims submission with the next step is real time adjudication.
- **Benefits to Medicaid**
  - Immediate processing to payment for Medicaid claims,
  - More efficient Medicaid Operations
  - Greater provider satisfaction through self service portal
  - Ability to use clinical data in payment decisions
  - Ability to verify billing information with clinical data
  - Improve security and privacy of PHI
- **Implementation Pathway**
  - Implement existing provider claims capabilities in HIE
  - Implement exclusive capabilities through HIE
  - Implement real time claims adjudication

MMIS HIE Capabilities:

- AEVCS Claims Submission
- Electronic claims adjudication
- EPSDT Screening results reporting
- Eligibility record of prior Medicaid coverage
- MMIS review/use of clinical information
- Third party payment avoidance

Claims Processing



- Reduce duplication of claims submission by practitioners
- Enable providers to adjudicate claims at time of service

Eligibility Verification

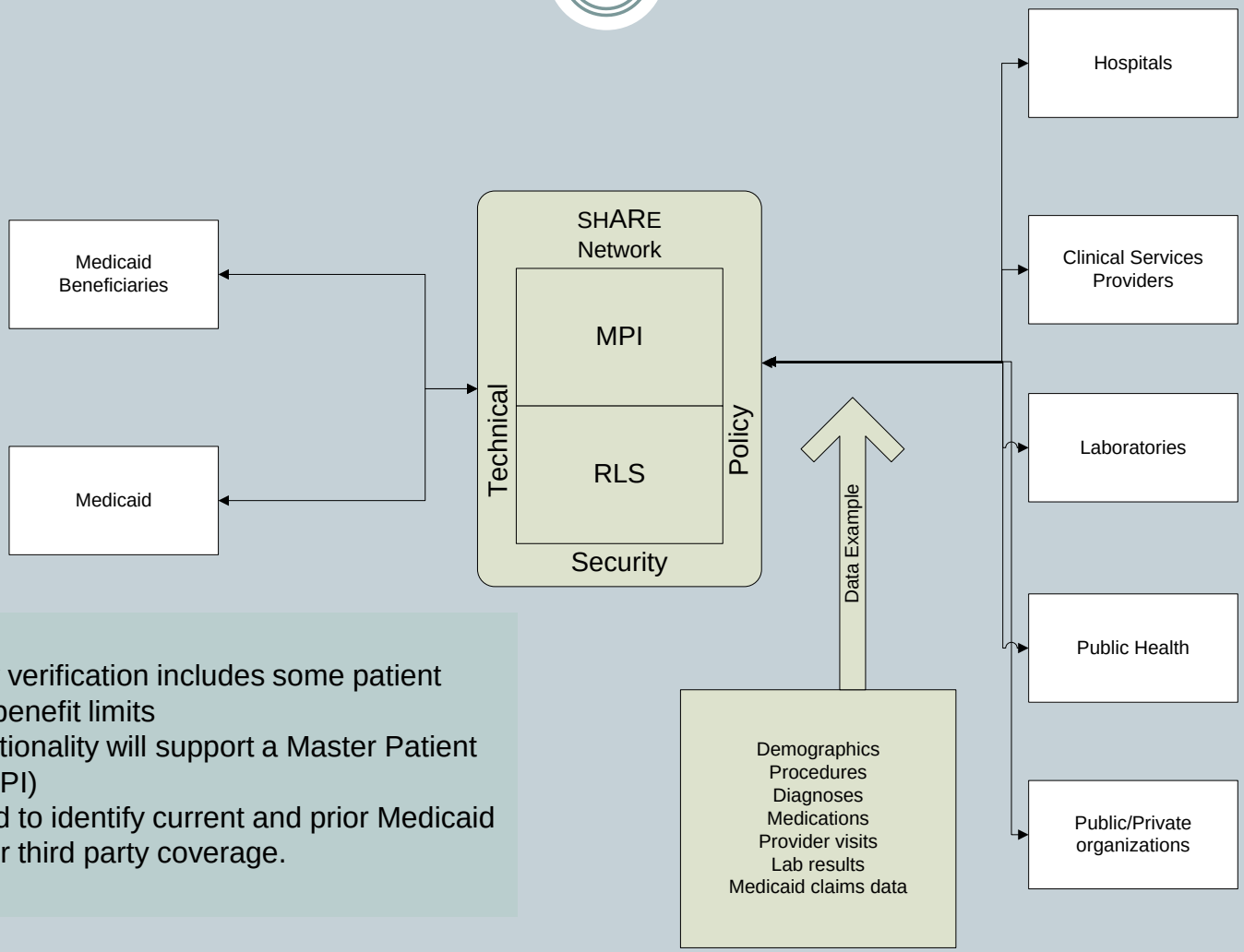
Medicaid eligibility at the point of service enables providers to verify eligibility, obtain billing information and determine benefit coverage and service limitations.

- **Benefits to Medicaid**
  - Improve Medicaid eligibility through providers
  - Improve third party liability identification
  - Improve EDPST screening
  - Improve benefit plan limitation notification
  - Improve security and privacy of PHI
- **Implementation Pathway**
  - Implement eligibility verification capabilities in HIE
  - Implement exclusive eligibility verification capabilities through HIE

MMIS HIE Capabilities:

- AEVCS Electronic eligibility verification
- EPSDT screening status inquiry
- Eligibility record of prior Medicaid coverage
- Eligibility intake from business partners (hospitals)
- Third party insurance identification

Eligibility Verification



- Eligibility verification includes some patient specific benefit limits
- HIE functionality will support a Master Patient Index (MPI)
- MPI used to identify current and prior Medicaid and other third party coverage.

Referral Reporting

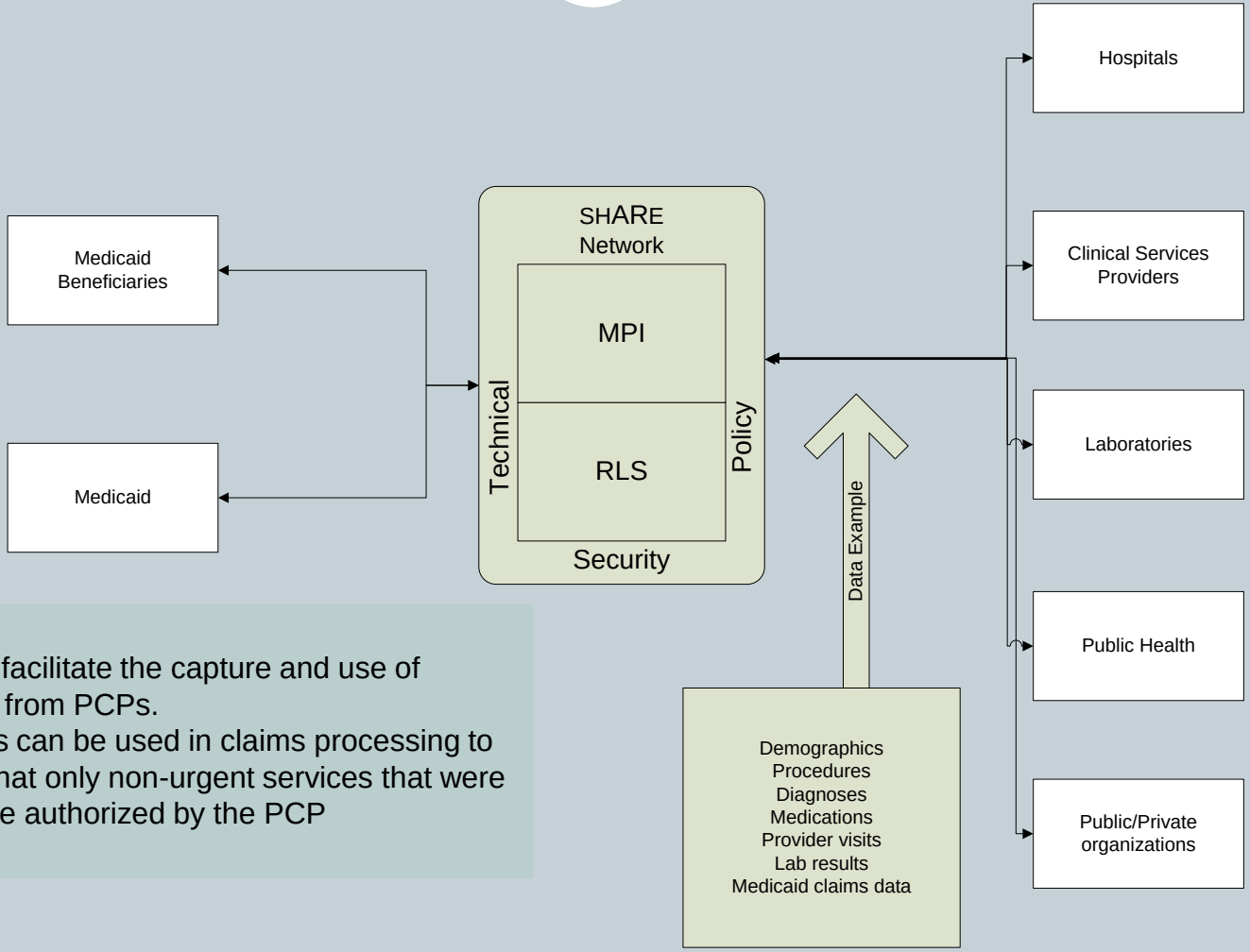
Providers generate referrals to other providers and forward a copy to Medicaid.

- **Benefits to Medicaid**
  - Access effectiveness of gatekeeper process
  - Limit specialty care to referred providers only
  - Analyze referral patterns and effectiveness of care
  - Identify potential fraud and abuse
  - Implement changes in reimbursement
  - Improve care coordination and case management
- **Implementation Pathway**
  - Implement referral capabilities in HIE
  - Implement exclusive referral capabilities through HIE

MMIS HIE Capabilities:

- Electronic referral processing (PCP to Specialist)
- Record of Services
  - Medication History
  - Inpatient
  - Ambulatory Visit
- Disease/case management for chronic care coordination
- Care coordination other treating providers/link

Referral Reporting



- HIE can facilitate the capture and use of referrals from PCPs.
- Referrals can be used in claims processing to ensure that only non-urgent services that were paid were authorized by the PCP

Quality Reporting

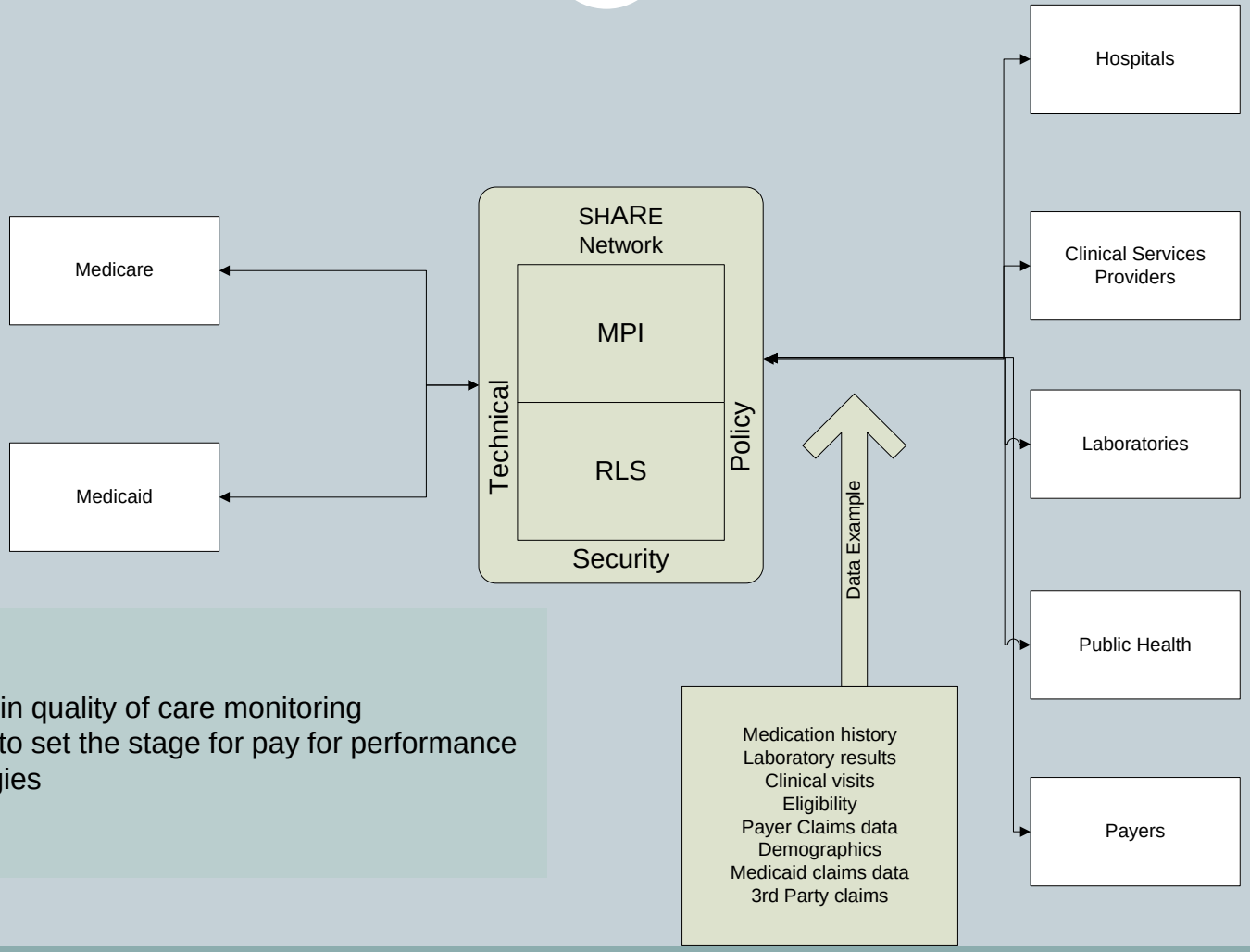
Medicaid collects data from providers who qualify for a Medicaid EHR incentive payment. Verification of meaningful use of EHR required of the providers who receive incentives.

- **Benefits to Medicaid**
  - Establish accountability for provider treatment
  - Establish criteria for Medicaid participation in PCCM
  - Verify Meaningful Use of EHR
  - Reimburse providers based on quality and outcomes
- **Implementation Pathway**
  - Require incentive providers to submit reporting through HIE
  - Require participating providers to submit reporting through HIE
  - Change reimbursement methodologies

MMIS HIE Capabilities:

- Audit/verification of meaningful use
- Chronic disease registries
- Immunization reporting
- EPSDT reporting
- MMIS review
  - Clinical Information

Quality Reporting



- Assist in quality of care monitoring
- Serve to set the stage for pay for performance strategies

Medical Home Care Coordination

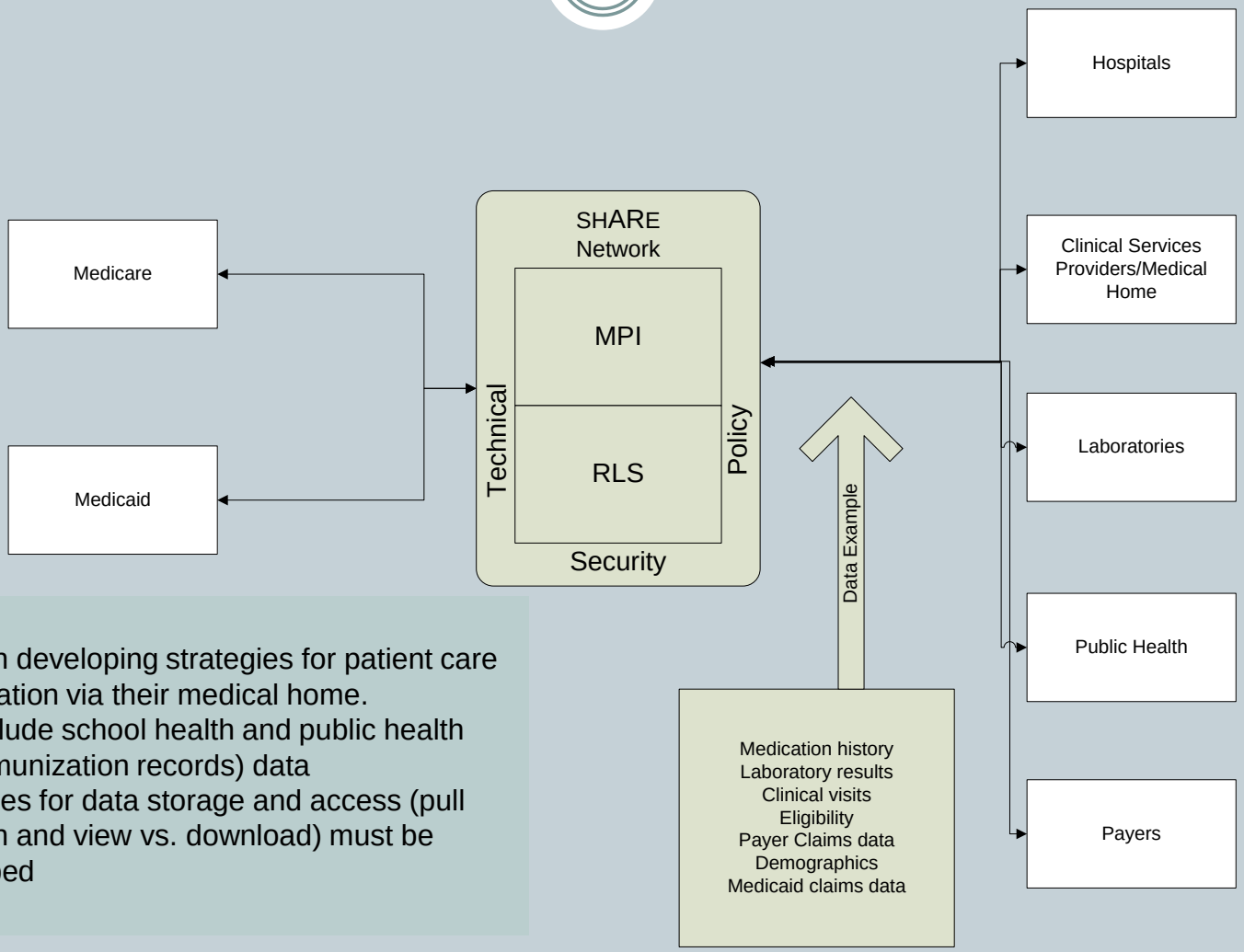
Medical home model is based on a patient centered care coordination & established as a cost effective/better care model. Facilitated through the widespread adoption of HIE and EHR.

- **Benefits to Medicaid**
  - Improve service utilization and effectiveness
  - Improve care coordination
  - Improve Long Term Care assessments
  - Reduce utilization of diagnostic tests
  - Provider adoption of EHR
  - Implement new payment methodologies
- **Implementation Pathway**
  - Provider access to Medicaid record of service
  - Medicaid alerts to providers
  - Web based HER light
  - Provider EHR
  - Patient feedback

MMIS HIE Capabilities:

- Disease/case management for chronic care coordination
- EPSDT screening status inquiry
- Electronic provider communication and alerts
- Care coordination - other treating providers/link
- Long term care patient assessments
- Verification of home and community based service (HCBS)
- EHR Light (in MMIS)

Medical Home Care Coordination



- Assist in developing strategies for patient care coordination via their medical home.
- Can include school health and public health (i.e. immunization records) data
- Strategies for data storage and access (pull vs. push and view vs. download) must be developed

Provider Identification

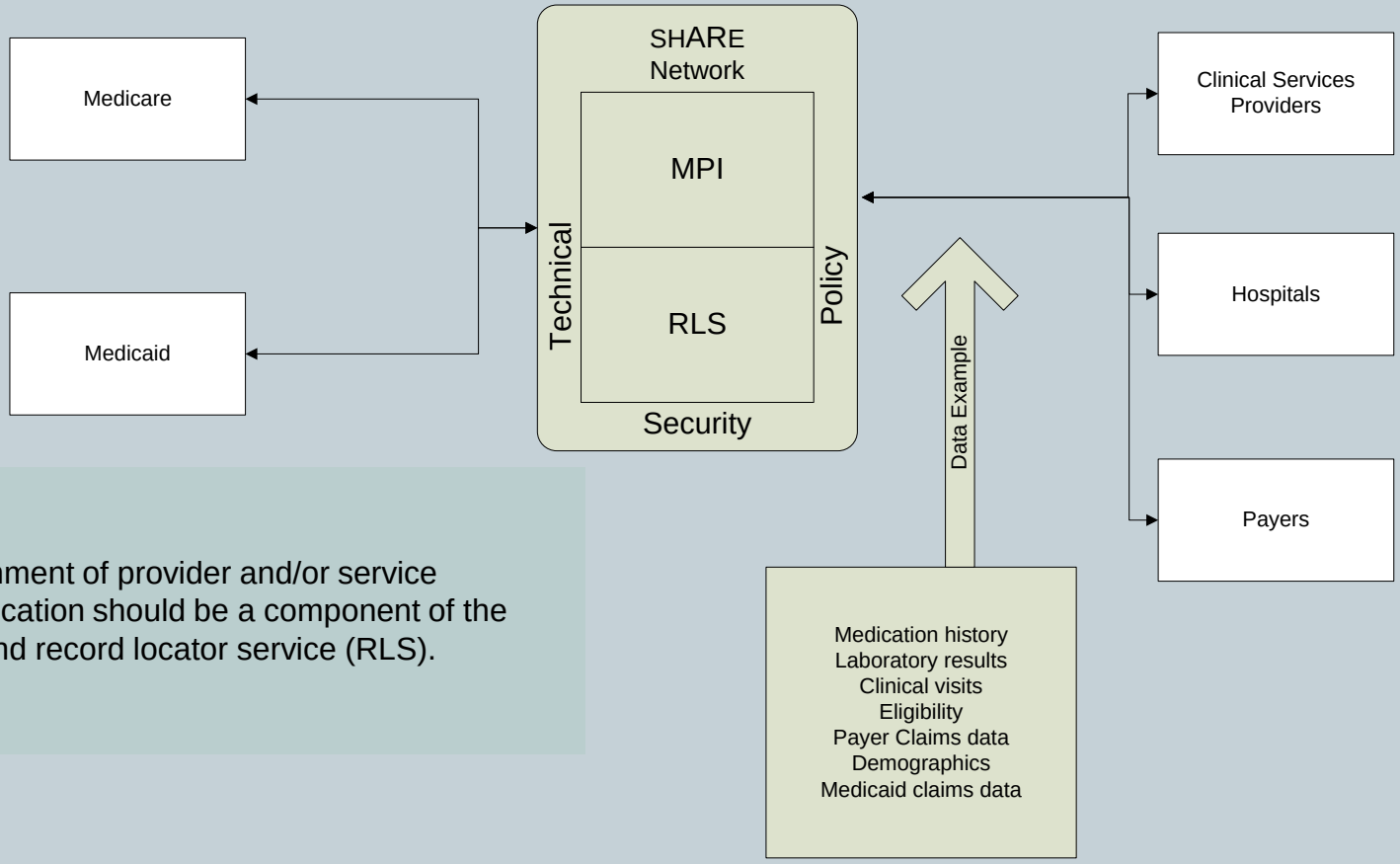
A master provider index is a foundation element in an HIE that provides secure identification and routing of information between HIE participants.

- **Benefits to Medicaid**
  - Self service provider enrollment/updates
  - Automated licensure verification
  - Improve provider communication
  - Improve fraud and abuse detection (point of treatment)
  - Improve access to care by patients
  - Improve security and privacy of information
- **Implementation Pathway**
  - Tie Medicaid provider data in to HIE provider index
  - Implement provider self service capabilities in MMIS
  - Implement provider communications through HIE

MMIS HIE Capabilities:

- Self service provider enrollment and update
- Electronic provider communication and alerts

Provider Identification



- Assignment of provider and/or service identification should be a component of the MPI and record locator service (RLS).

SHARE
Strategic Plan Update

Finance Strategic Plan

- Fox Feedback:
  - Introduction should really give a good preview of the entire document
  - Describe and document the results of the planning process, don't just describe the process itself
  - Suggested organizing by financing phases (pilot/proof of concept, implementation/operational, sustainability)
  - Too tentative, needs to be more specific throughout
  - Need to include Business Plan

Other Workgroup Updates

- BTO approved by EC with changes

Table 1 reflects the initial set of components and requirements proposed for incorporation in the Arkansas SHARE during the proof of concept and initial phases. A development timeline will be established to include this and future stages. Additional components and requirements to be incorporated as the SHARE's scope evolves include but will not be limited to payer claims adjudication, insurance eligibility reconciliation, and patient access to their health information.

Table 1. Proposed HIE Shared Services and Requirements

HIE Requirement
Master Patient Index (MPI)
Record Locator Service (RLS)
Record Demographics *Includes but not limited to name, date of birth, gender, race/ethnicity, insurance*
Record and Chart Vitals Information *Includes but not limited to height, weight, BMI, smoking status*
Diagnosis/Problems List/Health Issues
Diagnostic Test Results
Prescription and Medication Information *Includes but not limited to active medication list and activie medication allergy list*
Visit/Encounter Information
Clinical Summaries/Documentation
Immunization Registry Data Information
Public Health Information *Includes reportable lab results, syndromic surveillance data reporting*

Other Workgroup Updates

- Legal:
  - Presented to Executive Committee on April 16
  - Edited version to be presented to EC on May 7
- Communications
  - Working on draft
- Evaluation & Assessment
  - Working on draft
- Drafts of strategic plans are available on website after EC presentation, under Past EC Meetings
- All will be edited, synthesized & presented to EC, TF

SHARE
Finance Workgroup
Operational Plan

Operational Plan Components

- Components of Finance Operational Plan:
  - High-Level Budget Outlined
    - Phase 1 – pilot/proof of concept (July 2010-June 2011)
    - Phase 2 – implementation/operational (July-December 2011)
    - Phase 3 – sustainability (2012+)
  - Staffing Plan
  - Financial Management
    - Processes, timelines, milestones that relate to operational status
  - Controls & Reporting
    - DF&A, HHS, ARRA, etc.
  - Financing Plan & Business Model
    - Hybrid/mixed model

OUR CURRENT FOCUS

- Staffing Plan – BTO is working on
- Budget Amendment
  - 2010-2013 submitted budget: $7,909,401 HIE Cooperative Agreement funding (10% planning), $600,000 state matching, $600,000 Medicaid planning
  - Being amended based on new timeline, HIT office, staffing
- Long-term Revenue Stream Examples & Estimates
  - Subscription Plans (Utah, Maryland)
  - Claims Fees (Vermont, New Jersey)
  - Per Member Fee for Payers (New Mexico)
  - Public Utility Fee
  - Private Investment (California)
  - Grants – Federal and Private

Potential Revenue Streams

- Based on other states' experiences and/or their planned sustainability models
- Use those models with conservative estimates to give ballpark numbers for potential revenue streams
- Still need to consider:
  - Feasibility
  - Stakeholder support, concerns, issues
  - Barriers/issues to implementing
  - Potential solutions to implementing, including timeline required
  - Potential combinations of various revenue streams

Utah Subscription Plans – 2010 Annual Fees

- Administrative (UHIN) – core services for claims processing
  - Includes Speedi, credentialing system accepted by most Utah payers
  - Discounts for Utah Med Assn & Utah Hosp. Assn members
  - CLINICIANS: 1 provider $240, 25-29 providers $3,600, 100+ providers $14,400, integrated health systems $39,600
  - HOSPITALS: small $770, medium $3,300, large $8,600, integrated health system $36,000
  - PAYERS: $0.17 per non-Medicare claim and/or encounter, $0.028 per remittance advice (claims) + $0.02 per Medicaid transaction
- Add National Payer Clearinghouse, MedAvant & Emdeon
  - +20% of annual fee
- Add Claredi to certify HIPAA transactions
  - +$700 for Medical Practices, +$1,400 for Hospitals, +$5,600 for Payers or Professional Billing Services (fees are per certifying enpoint)

Utah Subscription Plans – 2010 Annual Fees

- Clinical (cHIE) – exchange of critical health information
  - Services: Access to patient clinical data (medication history, labs, allergies, immunizations, current issues, notes); referrals with other members; access to Medicaid and other payer formulary
  - Pricing (some discounts/fee waivers available):
    - CLINICIANS: 1 pays $600, 25-49 pays $6,580, 200-800 pays $28,189, 800+ pays $60,000, safety net providers pay $600 (community health centers, free clinics, Indian services)
    - HOSPITALS: charged on straight % of market share based on most recent inpatient data published by Utah Dept of Health
    - PAYERS have 2 options: $.085 PMPM (per member per month) with 250,000 member cap OR click fee option of $0.21 per 837 with same max amount as PMPM option

Maryland Draft Subscription Plan

Model Assumptions	Adoption Rates					
Use Cases	**Subscription/ Month**	**Assessment Unit**	**2010**	**2011**	**2012**	**2013**
National Laboratory Results Delivery	$10	Per doc	30%	50%	70%	90%
Hospital Laboratory Results Delivery	$2	Per doc	10%	30%	50%	70%
Local Laboratory Results Delivery	$3	Per doc	10%	30%	50%	70%
ED/Hospital Discharge Summaries to Physicians/Clinics	$10	Per doc	10%	30%	50%	70%
ED/Hospital Discharge Summaries to ED/Hospital	$2,000	Per facility	10%	30%	50%	70%
Clinical Summary to EDs	$2,000	Per facility	0%	0%	30%	50%
Clinical Summary to Physicians/Clinics	$10	Per doc	0%	0%	10%	30%
National Radiology Results Delivery	$5	Per doc	0%	30%	50%	70%
National Radiology Results History	$1,000	Per facility	0%	30%	50%	70%
Hospital Radiology Results Delivery	$1	Per doc	0%	0%	10%	30%
Hospital Radiology Results History	$350	Per facility	0%	0%	10%	30%
Local Radiology Results Delivery	$2	Per doc	0%	0%	10%	30%
Local Radiology Results History	$650	Per facility	0%	0%	10%	30%
Max Subscription – All Services	**$43**	**Per doc**				
Max Subscription – All Services	**$6,000**	**Per facility**				

AR Estimated Subscription Plan

- Arkansas Estimate for tiered Subscription Plan
  - 65,000 Licensed Providers (NOT practicing)
    - Admin Plan: if 25% paid avg $50/year = $812,500/year
    - Clinical Plan: if 25% paid avg $200/year = $3,250,000/year
  - 100 Hospitals
    - Admin Plan: if 40% paid avg $2,000/year = $80,000/year
    - Clinical Plan: if 40% paid avg $5,000/year = $200,000/year
  - Payers (assuming 1.9mm insured, approx 30% have 2 non-Medicaid claims)
    - Admin Plan (based on EBD, BC/BS & Other numbers) = $25,000
    - Clinical Plan (based on EBD, BC/BS & Other numbers) = $321,810

- TOTAL ESTIMATED REVENUE: $4,689,310

NJ & VT CLAIMS FEES

- New Jersey
  - Legislation in 2010, no data yet
  - .199% on each claim paid
  - Collected quarterly
  - Used by NJ Office for e-HIT to implement a state HIT plan
- Vermont (approx. 620,000 population)
  - .199% on each claim paid
  - Collected quarterly
  - 2010 report shows approx $2,158,000 in FY2010 charges
  - Data incomplete – almost ½ of required companies didn't report
  - Funds may be used by VITL as well as other HIT-related entities through formal request for disbursement

AR Estimated Claims Fee Plan

- Arkansas Estimate for fee of 0.1% of claims paid
  - EBD
    - Approx. 131,000 lives, estimate $430 million claims/year ($3,250/member)
    - revenue to HIT fund $430,000/year
  - Blue Cross Blue Shield
    - Approx. 1,000,000 lives, estimate $2 billion claims/year ($2,000/member)
    - revenue to HIT fund $2,000,000/year
  - Other
    - 250,000 lives, estimate $500 million claims/year ($2,000/member)
    - Revenue to HIT fund $500,000/year
- TOTAL ESTIMATED REVENUE: $2,930,000/year

PMPM Payer Fee Plan (New Mexico)

- Per Member Per Month (PMPM) Fee:

Summary of NMHIC Revenue Projections

	2008 Year 1	2009 Year 2	2010 Year 3	2011 Year 4	2012 Year 5
Revenue from Clinician Users of the Network (Network Subscription Agreements – NSAs)	-	-	-	-	-
Revenue from Payers					
▪ Number of Covered Lives	-	-	1.25 M	1.25 M	1.25 M
▪ Rate Per Member Per Month	-	-	$0.201	$0.201	$0.201
▪ Total Revenue from Payers	-	-	$3.01 M	$3.01 M	$3.01 M
Revenue from Government					
▪ State of New Mexico	$0.58 M	-	-	-	-
▪ Federal					
▪ Base Year 2008	$3.06 M	-	-	-	-
▪ Carry Over to 2009	-	$0.38 M	-	-	-
▪ Option Year One - 2009	-	$1.40 M	-	-	-
▪ Total Funds from Government	$3.64 M	$1.78 M	-	-	-
Total Revenue	**$3.64 M**	**$1.78 M**	**$3.01 M**	**$3.01 M**	**$3.01 M**

AR Estimated PMPM Payer Fee Plan

- Arkansas Estimate for PMPM Fee
  - Medicaid (estimate 714,000 = 25% of Arkansas population)
    - $.05/member/month = $35,700/month, $428,400/year
    - $.10/member/month = $71,400/month, $856,800/year
  - EBD (estimate 131,000)
    - $.05/member/month = $6,550/month, $78,600/year
    - $.10/member/month = $ 13,100/month, $157,200/year
  - Blue Cross Blue Shield (estimate 1,000,000)
    - $.05/member/month = $50,000/month, $600,000/year
    - $.10/member/month = $100,000/month, $1,200,000/year
- TOTAL ESTIMATED REVENUE (1,845,000 insured):
  - $.05/month = $1,107,000/year
  - $.10/month = $2,214,000/year

Public Utility Fee Plan

- Public Utility Fee – Telephone Lines
  - Approx 1,200,000 Telephone lines in AR (2008)
    - $2/year/line = $2,400,000/year
- Public Utility Fee – Internet Connections
  - Approx 480,000 Internet connections in AR (estimated 40% of 1.2mm households)
    - $2/year/line = $960,000/year
- TOTAL ESTIMATED REVENUE (both): $3,360,000/year

Private Investment (California)

- Exploring opportunities in venture capital, bank financing (large banks, community banks) and the bond market
- Considering using for up-front costs, not long-term
- Not assuming availability, especially given current capital market
- Planning and doing research now to meet repayment qualifications so HIE is prepared to take advantage of possible opportunities
- AR TOTAL ESTIMATED REVENUE: $0

Federal & Private Grants

- Grants – Federal
  - Some amount of future federal grants probable for HIE
  - Should not be part of sustainability plan, but could be used for future improvement and/or expansion of SHARE functionalities
- Grants – Private
  - Many states have used in the past to help build HIE
  - Limited private funds available at this point in time
  - Arkansas not likely to receive, shouldn't focus time
- AR TOTAL ESTIMATED REVENUE: $0

Questions to Consider

- Is there any single revenue source to sustain SHARE?
- How realistic is each revenue option for Arkansas sustainability?
- Which combination might work best?
- What are pros and cons of each option?
- How might we change other states approaches to match more closely with needs of Arkansas?
- What fluctuations can we expect over time from various fees? (ie hope to decrease claims decrease with HIE, so claim fee revenue would decrease)
- Are there any other options we should be considering?

SHARE
Finance Workgroup

Next Steps

Strategic & Operational Plans

- Strategic Plan
  - Staff is editing and finalizing
  - Fianance will be incorporated with other parts and sent to Executive Committee for final approval
- Operational Plan
  - Staff will draft a draft plan based on WG input
  - Workgroup will give comments draft
  - Staff will finalize draft
  - Randy will present to Executive Committee for discussion/approval
  - Staff will finalize and send to editor to be incorporated with other parts of Operational Plan